PHO Alliance
He huinga ratonga hauora

Primary Health Alliance
He huinga ratonga hauora

Together we achieve more

Strategic Plan

1st July 2016 to 30th June 2019

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1 BACKGROUND

1.1 The PHO Alliance was formally established as an Incorporated Society in September 2006 to provide national leadership on key issues affecting the Primary Health Care Strategy and Primary Health Organisations (PHOs) in New Zealand.

1.2 This Strategic Plan, which is published on the 10th anniversary of the organisation, has been developed through a comprehensive process of collaboration and consultation with the Executive Committee and member organisations and has included:

- A member (and non-member) survey undertaken through an independent facilitator during July and August 2015
- An open discussion with members at the PHO Alliance membership meeting in December 2015
- A strategically focused discussion with members at the PHO Alliance membership meeting in March 2016
- A formal review of the draft Strategy at the PHO Alliance membership meeting in June 2016

1.3 During this process members noted that significant recent successes of the PHO Alliance included the following:

- PSAAP and national contract negotiation/representation with significantly increased recognition of the PHO Alliance and influence at the national negotiating table
- Clinical leadership and the input of PHO Alliance GP chairs into national forums/working groups
- Policy influence through recent policy discussion papers (e.g. A time to act, Targeting Resources)
- Joint working with Heart Foundation and Health Promotion Agency (including national best practice symposiums)
- Wider sector engagement with membership now including Allied Health, Pharmacy, Kidney Health etc
- National profile with regular input into national steering groups (e.g. IPIF Governance) and meetings with national influencers
- Operational and financial management – continued strength of operations within the low-cost membership model

1.4 This Strategic Plan now sets out the intention of the organisations to continue to add value for its members for the coming three years, 1 July 2016 to 30 June 2019. However, the organisation and its membership will remain very cognisant of the evolving health landscape and in that regard will ensure that the Strategy remains fit-for-purpose alongside national policy developments and the emerging refreshed New Zealand Health Strategy. Similarly, the outcome of on-going sector unification discussions with partners such as General Practice New Zealand, may make it necessary for this Strategy to be specifically reviewed during its three-year timeframe.

2. THE HEALTH LANDSCAPE

2.1 The health landscape in which member organisations have been operating continues to be challenging, fast moving and ever-changing. However, the original New Zealand Health Strategy of 2000, the 2001 Primary Health Care Strategy and the emerging 2016 Health Strategy refresh process all place PHOs and the wider primary and community health sectors in key roles to deliver:

- A patient focused model of care
- Care closer to home (including secondary to primary care redesign)
- Greater support for DHBs to enable them to meet the Minister's expectation of increased primary care capacity and capability
- A greater focus on prevention and health promotion activities (including the wider determinants of health)
- Integrated care delivered through multi-agency and multi-professional approaches

2.2 In recognition of a broader focus on the wider determinants of health and delivering integrated care through multi-agency, multi-professional approaches, PHOs have embraced the need to develop important strategic and operational relationships with key partners from across the health and social care sector as well as broader agencies such as education, housing and the private sector.

2.3 To support such a wider, multi-agency approach, PHO Alliance members sought and encouraged a broader operating scope and membership criteria for the PHO Alliance. Members have embraced a broader membership including organisations which directly hold, or represent interests which directly hold a primary care contract as well as partner organisations who themselves have a direct role to play in supporting better health outcomes for the people of New Zealand and whose objectives align with the charitable objectives of the PHO Alliance.

2.4 Those objectives, set out below, are now more than ever, vital to supporting member organisations and their local community partners and stakeholders to deliver better health outcomes for their local population with a particular emphasis on Maori, Pacific and high need communities who are more vulnerable and whose health outcomes are currently poorer.

2.5 Recognising the wider primary and community interests represented within the broader membership, members have supported a change of name and a transition in branding from a PHO focused organisation to one encompassing those wider members, partners and stakeholders. To coincide with the publication of this Strategic Plan, The PHO Alliance became the Primary Health Alliance and will be dual branded for a transitional period – a significant and deliberate move which is underpinned by dual logos, appropriately branded websites and supporting organisational collateral.

3 VISION AND OBJECTIVES

3.1 In recognition of the greater sector-wide scope of the Primary Health Alliance, the Vision and Objectives which have served the organisation and its membership well for the past 10 years, have now been strengthened to remain fit-for-purpose and to drive the priorities of the organisation over the coming years.

3.2 The refreshed Vision of the Primary Health Alliance is:

Vision:

..to support the development, exchange and promotion of policies and strategies which advance health outcomes for the population of New Zealand through our member organisations.

3.3 The refreshed objectives of the Primary Health Alliance, which will be reflected in the refreshed Constitution, are:

Charitable Objectives:

a. *Advocate, with regards to health and wellbeing, on behalf of Members for the benefit of the population of New Zealand.*

b. *Promote primary and community health through integrated multi-agency and multi-professional partnerships.*

c. *Foster effective partnerships between providers and communities.*

d. *Foster and nurture key strategic relationships at a local and national level.*

e. *Encourage collaboration and the sharing of resources, good practice and information across Members and the wider sector.*

f. *Contribute to the development and implementation of health policy at a national level.*

g. *Promote and support enrolled list-based primary and community care.*

h. *Promote General Practitioners as overarching clinical guardians for patient level primary and community care supported where appropriate by nominated care co-ordinators.*

i. *Carry out other activities consistent with the charitable objectives of the society.*

4. ADVOCACY AND REPRESENTATION

4.1 One of the primary objectives of the Primary Health Alliance is to advocate for and represent members' interests with key partners and stakeholders. The Primary Health Alliance will continue to do so either directly on members' behalf or through shared member-led 'consortia' type arrangements. This has successfully included, and will continue to include, the following examples:

4.2 Influencing Policy:

- The Primary Health Alliance (and previously the PHO Alliance) has considerably raised its profile on the national stage through its input into health strategy and policy development in the form of its policy discussion papers - A time to act (February 2015), A time to act: Implementation solutions (May 2015) and, Targeting Resources: Strengthening New Zealand's primary care capitation funding formula (December 2015). The Primary Health Alliance will continue to target capacity to policy discussion papers with carefully selected subject areas and facilitated input from experts within and external to the Primary Health Alliance membership.
- The Primary Health Alliance will continue to seek and accept membership opportunities to input into other relevant health and social care forums. Such existing examples include the working group on the review of primary care funding, IPIF governance arrangements and the emerging Healthcare Home governance forum.

Member Benefit and Value:

- Significant influence through collective strength of voice.
- Value-for-money approach through consortia led arrangements.

4.3 Key stakeholder relationship management:

- To underpin its advocacy work, the Primary Health Alliance will continue to seek and maintain professional and individual relationships with key stakeholders and influencers. Such relationships will include but not be limited to: Politicians and their advisory teams; Departmental officials, the media, leaders of partner agencies and stakeholders.

4.4 Contract negotiation:

- A significant component of all PHOs income continues to be derived through the PHO Services Agreement between individual PHOs and their District Health Board(s). The core contract is negotiated and developed nationally through the PHO Services Agreement Amendment Protocol Group (PSAAP). The Primary Health Alliance will continue the strong role that the PHO Alliance has played for many years in ensuring members' interests are appropriately represented at the PSAAP table and members are engaged in a totally transparent, responsive and timely two-way communication and decision making process to inform the Primary Health Alliance's negotiator's mandate on their behalf.

4.5 To ensure that the key messages from the above advocacy and representation work are heard by their intended audience, the Executive Committee will maintain a 'communications' budget to fund a professional design and circulation of the Primary Health Alliance's policy discussion papers, annual reports and other associated material. This will further raise the credibility and professionalism of the Primary Health Alliance advocacy and representation role.

5. SECTOR WIDE COLLABORATION

5.1 The collective benefits and strength of voice to be secured through collaborative working across primary, community and social care sector partners is well documented. The existing role of PSAAP in this regard has always formed a key component of the PHO Alliance Strategy on behalf of members.

5.2 The Primary Health Alliance recognises that the PSAAP forum and associated primary care caucus currently (mid-2016) offers the only platform through which every PHO is formally represented and also includes wider sector representatives (GPLF). This is an effective forum for discussing differences within the sector and subsequently presenting a cohesive and aligned front for the common good. The Primary Health Alliance will seek to reinforce its position within the forum on behalf of members and further optimise the sector wide collaboration undertaken through this forum.

Member Benefit and Value:

- Maintenance of key cross-agency relationships to support wider determinants of health.
- Cohesive and aligned sector.

5.3 In aiming to support such a cohesive and aligned sector, the Primary Health Alliance will continue to be cognisant and respectful of the subtle but key differences in the interests of the various constituencies represented across the sector (including those of the Primary Health Alliance) and the value placed by those constituencies on maintaining an element of independence.

5.4 The Primary Health Alliance formally recognises (and will continue to work closely with and in partnership with) all PHO representative groupings at a national level and the role they all have to play in support of members objectives. Such groupings notably include:

- The PSAAP full primary care caucus including all PHOs and the GPLF
- The Maori, Pacific and high needs caucus– maintaining a specific focus and strong voice against inequalities, including the National Hauora Coalition (NHC), Heath Care Aotearoa (HCA), Hauraki PHO and others
- The Health care home collaborative – including the 'N4' networks associated governance forum
- General Practice New Zealand, whose membership includes some joint PHO members of the Primary Health Alliance

5.5 The Primary Health Alliance will seek to further enhance its collaboration to include key relationships across Government Agencies spanning the wider determinants of health as well as District Health Boards and key Social Care partners including NGOs.

5.6 To date, in support of such a multi-agency approach, the PHO Alliance has been delighted to work alongside and develop constructive relationships with a wide range of agencies and key stakeholders. The contribution of non-PHO interests to the delivery of this Strategic Plan is strongly acknowledged and includes key partners such as Allied Health, the HPA, the Heart Foundation, Kidney Health NZ and the Pharmaceutical Society of New Zealand. The Primary Health Alliance will continue to build on this vital multi-agency approach and the Executive Committee will seek to identify increased capacity to extend the level of sector-wide collaboration and engagement on behalf of all members.

6. SHARING RESOURCES AND BEST PRACTICE

6.1 Quite possibly the most altruistic of the Primary Health Alliance membership benefits is that of sharing resources and good practice to improve health outcomes for the whole population of New Zealand.

6.2 The Primary Health Alliance will continue to proactively seek all opportunities to avoid 'reinventing the wheel'. This will include working on a consortia basis wherever possible to make best use of limited manpower and resources in smaller and mid-sized member PHOs, as well as openly sharing learning and successful approaches between localities which may often be at different ends of the country.

6.3 On behalf of members this activity will include, but not be limited to:

- Structured quarterly member meetings with significant opportunity for networking, formal exchange of innovation and ideas between members and, expert guest presentations covering issues such as policy developments, thought leadership, innovative health design
- Regular e-communications and information sharing with the latest news, learnings and innovations from members and across the wider sector nationally and internationally
- Lead consortia arrangements supporting individual member representatives to lead on particular projects or innovations on behalf of all members
- National workshops and symposiums to provide "Best Practice Learning" from across the sector open to all PHOs, NGOs, DHBs and partners
- Strengthened on-line sharing of learning and innovation from around the country showcasing successful innovation as well as sharing the unforeseen barriers and hurdles associated with projects and pilots which haven't delivered the anticipated benefits.

Member Benefit and Value:

- Shared learning to support quality and patient level outcomes.
- Optimal use of collective resources.

6.4 In addition, the traditional analysis and shared learning between members in relation to national health targets and to historic PHO Performance Programme (PPP) / Integrated Performance and Incentive Framework indicators will continue. Success will see Primary Health Alliance members continuing to feature strongly in the top performing PHOs/localities with the publication of each quarter's performance data.

7. PRIMARY HEALTH ALLIANCE OPERATING MODEL

7.1 Member feedback has been consistently positive regarding the unique principles of operation which the PHO Alliance has historically adopted to underpin its membership offering. One of the key strengths of those management and operating arrangements is the widely regarded value for money membership. Management and operating costs are minimised due to the following key operational arrangements/principles which will continue to underpin the future Primary Health Alliance operations:

- A regular 'consortia' approach with direct input from members to working groups and projects either collectively or on behalf of all members. This will include, but not be limited to:
  - The long standing PSAAP negotiation and representation arrangements which sees members collectively agree a mandate for a nominated lead negotiator
  - The recently established 'Finance Managers Forum' to share views and expertise relating to matters such as the imminent regulatory changes to financial reporting across all PHOs/members
  - Members' and their staff input to symposiums for sharing good practice (including funding and logistical support provided by the Heart Foundation and HPA as well as speakers and presenters from PHOs)

Member Benefit and Value:

- Fully transparent low cost, high value membership offering.
- Direct input, influence and development of members and their teams

- Procurement of all management services, office services and IT requirements predominantly through a low cost 'contract for services'. The PHO Alliance has typically not directly employed any staff nor owns or leases any premises or assets through which to undertake its operations.

7.2 The Primary Health Alliance will:

- Continue to run a low-cost operating model
- Continue to offer a low-cost high-value membership model which adds significant additional value through the collective 'in-kind' contributions made by members
- Continue to maintain its independence of operation without need to support its sustainability through additional or potentially conflicting external contracts

7.3 Subject to available resources, the Executive Committee will additionally seek to:

- explore the option to increase the scope and volume of the management 'contract for services' to provide additional capacity to underpin delivery of the organisation's objectives
- potentially utilise a member's or partner's Wellington premises to increase the 'presence' and visibility of the Primary Health Alliance on behalf of members with key Wellington based stakeholders
- Offer a range of additional membership services such as staff developmental programme (e.g. self-directed learning programme and learning sets), scholarship opportunities for emerging leaders and international study tours.

8. PRIMARY HEALTH ALLIANCE GOVERNANCE STRUCTURE

8.1 The overall governance of the Primary Health Alliance will continue to be undertaken by an Executive Committee directly elected annually as a function of the Annual General Meeting by individual members in line with the constitution of the organisation. The Executive Committee will have a minimum of 3 and a maximum of 7 elected members. In addition, it will have any number of additional co-opted members as required to provide the capacity and capability deemed necessary by the Executive Committee for the effective Governance of the organisation on behalf of members.

8.2 The Executive Committee have responsibility for operationalising and delivery of the Primary Health Alliance Strategic Plan as approved and adopted by the full voting membership. It must be emphasised that the Strategic Plan will continue to be directly guided and determined by all members.

8.3 A Chief Executive will continue to be responsible for the day-to-day running of the organisation through direct accountability to the Chair and supported by the guidance of the Executive Committee.

Member Benefit and Value:

- Governance determined by members, for members.
- Structured and responsive framework of collective expertise.

8.4 The Executive Committee will continue to utilise appropriate sub-committees where required to fulfil and effectively discharge the charitable objectives of the Primary Health Alliance. Each sub-committee will usually be chaired by a member of the Executive Committee who will be designated as the Primary Health Alliance lead for the remit of each sub-committee. The role of each sub-committee chair will therefore include, on behalf of all members:

- To be recognised as the 'champion' for the relevant subject area
- To develop and oversee the work-plan of the sub-committee and present it to the Executive Committee for endorsement
- To support the appropriate development of members including the sharing of best practice and promulgation of learning
- Where agreed with the Primary Health Alliance chair, acting as spokesperson with external agencies such as the Ministry of Health and the media
- To represent the Primary Health Alliance, and members, on external working groups, panels and national forums as appropriate

8.5 The membership of each sub-committee will be determined by the relevant sub-committee chair and may include external [non-member] partners and stakeholders as well as Primary Health Alliance members as necessary to fulfil its work-plan on behalf of members. The sub-committees may often be time-limited to focus on a particular project only and meet as frequently as necessary, using a range of electronic or face-to-face forums. It is anticipated that members may undertake actions between meetings, with the support of the Chief Executive, to ensure that each sub-committee continues to add-value to all members.

8.6 The number and scope of sub-committees will be managed to ensure they do not exceed capacity and capability to deliver and may cover issues which include Clinical Leadership and Integration, Rural Health, Maori and Pacific Health, Finance, PHO Performance, PHO Services Agreement Amendment Protocol Group (PSAAP).

9. MEASURING SUCCESS

9.1 In consultation with the full membership, the Executive Committee will periodically agree key success factors to ensure appropriate delivery of this Strategic Plan and the on-going value proposition for members. Such success factors may cover the areas of profile, presence and participation and may include specific measures such as:

- Devolution of services from secondary care
- Increase in targeted funding
- % of funding utilised on front-line care

10. MONITORING AND REVIEW

10.1 This Strategic Plan will be reviewed annually by the Executive Committee who will be responsible for providing a progress report and update to members at the Annual General Meeting.

10.2 Additionally, in light of the emerging refresh of the New Zealand Health Strategy being undertaken by the Ministry of Health at the same time as the development of this Strategy, the first review undertaken by the Executive Committee will explicitly include a process to ensure that it remains aligned with and cognisant of the national strategy.

Charitable Objects	Initiatives	Lead	Measures/Outcomes
Advocate, with regards to health and wellbeing, on behalf of Members for the benefit of the population of New Zealand.	Maximise media exposure and public engagement opportunities on behalf of Primary Health Alliance	• Chair • Chief Executive	• Number of media comments/appearances • Number of public engagement opportunities
	Optimise face-to-face and direct communications with Ministry of Health and associated key stakeholders	• Chair • Chief Executive	• Number of meetings with MoH et al • Number of appropriate other communications with MoH et al
	Provide professional and robust written responses on behalf of members to relevant national consultations	• Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Number of appropriate consultation responses submitted
	Secure representation on appropriate national working groups / steering groups	• Relevant sub-committee Chairs • Chief Executive • Executive Committee • All members	• Number of national working-group meetings attended
Promote primary and community health through integrated multi-agency and multi-professional partnerships.	Maximise national opportunities to promote community health focus and priority for high needs communities through media comments and relevant communications with MoH and other Government Departments	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee • All members	• Number of media comments/appearances • Number of public engagement opportunities • Number of relevant communications with MoH / Government Departments • Number of relevant working-groups attended
	Maximise engagement with appropriate 'community' partners and stakeholders and secure national Memoranda of Understanding where relevant/beneficial	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Number of appropriate partners / stakeholders engaged with • Number of relevant Memoranda of Understanding agreed
Foster effective partnerships between providers and communities.	Maximise appropriate contacts and relationships with providers/ representatives including: • DHBs • GPNZ, RNZCGP, NZMA • National Hauora Coalition • Health Care Aotearoa	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Number of meetings/engagements with appropriate provider or provider representative organisations
Foster and nurture key strategic relationships at a local and national level.	Maximise appropriate contacts and relationships with strategic partners including: • Ministers • Opposition leaders • Government Departments (inc MoH) • Other key national organisations	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Number of meetings/engagements with appropriate partners / stakeholders
Encourage collaboration and the sharing of resources, good practice and information across members and the wider sector.	Optimise face-to-face engagement and sharing of best-practice between members	• Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Number of members meetings held • Number of relevant agenda items / presentations re sharing best practice
	Maximise web-site / IT to facilitate sharing of information and resource between members	• Chief Executive	• Up-to-date website • Level of utilisation of electronic exchange of information

Charitable Objects	Initiatives	Lead	Measures/Outcomes
	Secure learning from external experts	• Relevant sub-committee Chairs • Executive Director • Executive Committee	• Number of external 'experts' secured for member meetings • Number of additional training / workshop courses secured for members
	Optimise opportunities to collaborate with other sector representatives	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee • All members	• Number of joint working arrangements with other sector representatives
Contribute to the development and implementation of health policy at a national level.	Maximise Primary Health Alliance representation on relevant national working groups and policy fora	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee • All members	• Number of national working-group meetings attended
Promote and support enrolled list-based primary and community care. *Promote General Practitioners as overarching clinical guardians for patient level primary and community care supported where appropriate by nominated care co-ordinators.*	Promote clinical leadership and engagement wherever possible	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee • All members	• GP representation upon Executive Committee • Effective establishment of Clinical Leadership and Integration sub-committee • Number of media comments/appearances • Number of public engagement opportunities
	Maximise opportunities to proactively engage with relevant general practice providers and representative organisations	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Number of joint working arrangements with General Practice organisations including RNCZGP, NZMA, GPNZ • Number of engagements and maintenance of relationships with other key general practice providers / support organisations including Southlink, Radius etc
Carry out other activities consistent with the charitable objectives of the society.	Maintain effective sub-committees covering appropriate specialist subjects including: • Clinical leadership and integration • Rural health • Maori & Pacific health • Finance • PHO Performance	• Relevant sub-committee Chairs • Chief Executive	• Number of sub-committees working effectively • Number of sub-committee work-plans signed-off by Executive Committee • Feedback and minutes presented to Executive Committee
	Maximise opportunity for Primary Health Alliance 'projects' including representation upon appropriate external projects/programmes	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee • All members	• Number of additional 'projects' engaged in

Charitable Objects	Initiatives	Lead	Measures/Outcomes
	Maximise Governance and operational efficiency of organisation	• Chair • Relevant sub-committee Chairs • Chief Executive • Executive Committee	• Timely and accurate production of agenda's, papers and minutes of General Meetings • Timely and accurate production of agenda's, papers and minutes of Executive Committee and sub-committee meetings • Robust financial management and production of timely and accurate financial performance reports • Timely and accurate production of annual report and annual accounts